MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3213

03199 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Millington
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BARNITTE Middle Last ASHLEY

4. DATE OF DEATH: Month March Day 22 Year 1959

5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October, 9, 1958
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months 5 Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baby
10b. KIND OF BUSINESS OR INDUSTRY: Baby
11. BIRTHPLACE (State or foreign country): Wilmington, Del.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Ashley
14. MOTHER'S MAIDEN NAME: Rosie Sudler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: James Ashley, Address: Millington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Spastic Bronchitis — INTERVAL BETWEEN ONSET AND DEATH: 4 weeks.

DUE TO (b): Common Cold — 4 weeks.

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 50%

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 13, 19 59 to March 19 59, that I last saw the deceased alive on March 19, 19 59, and that death occurred at 7:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Geza Koralewski M.D. ADDRESS (Street, city or town, state): MILLINGTON (MD) DATE SIGNED: 3-23-59

PHYSICIAN'S NAME (Type): GEZA KORALEWSKI

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March, 24, 1959
22c. NAME OF CEMETERY OR CREMATORY: Riley's Neck, Cemetery
22d. LOCATION (City, town, or county): Rural Millington, (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows ADDRESS: Millington Md.
24a. REC'D BY REGISTRAR DATE: MAR 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

3206 CERTIFICATE OF DEATH

Reg. Dist. No. 03200

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown, Md
c. LENGTH OF STAY IN 1b: 72 years

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 37 Chestertown
d. STREET ADDRESS: 1407 Washington Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent and Queen Anne Hospital

3. NAME OF DECEASED (Type or print): First HANNAH Middle Wetherill Last Bell

4. DATE OF DEATH: Month March Day 13 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 14, 1886
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher
10b. KIND OF BUSINESS OR INDUSTRY: Education
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Anthony Bell
14. MOTHER'S MAIDEN NAME: Geraldine Phillips

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-36-5082
17. INFORMANT: Miss Margaret Bell, Address: Chestertown, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3½ hrs.
331X
DUE TO
(b): Hypertension — 2 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Arteriosclerosis — 3 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 18, 1950, to March 13, 1959, that I last saw the deceased alive on March 13, 1959, and that death occurred at 12:55 p. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A.C. Bick M.D. — ADDRESS (Street, city or town, state): Chestertown, Maryland — DATE SIGNED: 3-13-59

PHYSICIAN'S NAME (Type): A.C. Bick

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 16/59
22c. NAME OF CEMETERY OR CREMATORY: St. Paul Cemetery
22d. LOCATION (City, town, or county) (State): Farrlee Kent Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Marvin V. Williams ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: MAR 18 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Hynson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3214

CERTIFICATE OF DEATH

03201

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): near - Chestertown
c. LENGTH OF STAY IN 1b: Adult life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: at home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X near - Chestertown, Md.
d. STREET ADDRESS: RFD # 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marion — Middle: Clark — Last: Blackiston

4. DATE OF DEATH: Month: Mar. — Day: 9, — Year: 1959

5. SEX: female

6. COLOR OR RACE: colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 14, 1878

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife & Laborer

10b. KIND OF BUSINESS OR INDUSTRY: retired

11. BIRTHPLACE (State or foreign country): St. Mary's Co. Md.

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: Laura Lawson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-24-1079

17. INFORMANT: Mrs. Marion Clarkson — Address: Chestertown, Md. RFD # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Angina Pectoris — INTERVAL BETWEEN ONSET AND DEATH
420.2
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. / Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/9, 1959, to 3/9, 1959, that I last saw the deceased alive on 3/9, 1959, and that death occurred at 5:2a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E J Kester, M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED: 3/10/59

PHYSICIAN'S NAME (Type): Eugene Kester — Rock Hall, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/12/59
22c. NAME OF CEMETERY OR CREMATORY: Asbury Cem. (Georgetown)
22d. LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Wallace — ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR — DATE: MAR 13 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kane

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3207

Reg. Dist. No. 03202

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Annes

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 37 Chestertown
d. STREET ADDRESS: 525 High Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John — Middle Henry — Last Chaires

4. DATE OF DEATH: March 16 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 12, 1879

9. AGE (In years last birthday): 79 Yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (State or foreign country): Queen Annes

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Chaires

14. MOTHER'S MAIDEN NAME: Sarah Cosden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 218-16-5401

17. INFORMANT — Address: Hospital Records Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5days

491X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic & Hypertensive Cardiovascular disease with failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/11/ 1959 to 3/16 1959, that I last saw the deceased alive on 3/16/ 1959, and that death occurred at 1:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W. Farr M.D.

ADDRESS (Street, city or town, state): Chestertown, Md.

DATE SIGNED: 3/16/59

PHYSICIAN'S NAME (Type): Robert W. Farr

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/18/59

22c. NAME OF CEMETERY OR CREMATORY: Chester Cem.

22d. LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells

ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR — DATE: MAR 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3208 — Reg. Dist. No. 03203

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Annes

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Worton(rural)
d. STREET ADDRESS: -
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: John Edward; Middle; Last: Dempsey

4. DATE OF DEATH: Month: March; Day: 3; Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 29, 1892

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Edward Dempsey

14. MOTHER'S MAIDEN NAME: Rose Overton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 215-38-1557

17. INFORMANT — Address: Hospital Records, Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Subarachnoid hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 36 hours
330 X
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 11, 1955, to March 3, 1959 that I last saw the deceased alive on 3/3, 1959, and that death occurred at 11:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W Farr M.D. — ADDRESS (Street, city or town, state): Chestertown Md. — DATE SIGNED: 3/3/59

PHYSICIAN'S NAME (Type): Robert W. Farr

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3-7-59
22c. NAME OF CEMETERY OR CREMATORY: STILL POND CEMTY
22d. LOCATION (City, town, or county): STILL POND, (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: Victor N. Kennedy — ADDRESS: STILL POND, MD

24a. REC'D BY REGISTRAR — DATE: MAR 6 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03204

3215 Item 11 Filed 3-18-59 et Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall - Rural
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Tolchester
d. STREET ADDRESS: U S Army Nike Battery
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Walter — Middle: RICHARD — Last: FULBRIGHT

4. DATE OF DEATH: Month: March — Day: 1 — Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct 13, 1935
9. AGE (In years last birthday): 23 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. ARMY
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Greenville, S. C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Walter D. Fulbright
14. MOTHER'S MAIDEN NAME: Violet Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1956-1959
16. SOCIAL SECURITY NO: 260-50-7222
17. INFORMANT: Cpt Frederick Stevens Address: Niki Base Dorchester Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): MASSIVE FRACTURE BASE OF SKULL
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: Min.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Thrown from car which skidded & upset
20c. TIME OF INJURY: Hour: 2 00 p.m. — Month, Day, Year: 3/1 1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) (County) (State): Rock Hall Kent Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Robert W Farr M.D.
EXAMINER'S NAME (Type): ROBERT W FARR
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3/11/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 3 March 59
22c. NAME OF CEMETERY OR CREMATORY:
22d. LOCATION (City, town, or county) (State): Savannah, Georgia

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L Lane ADDRESS: Church Hill Md
24a. REC'D BY REGISTRAR DATE: Mar 12 59
24b. REGISTRAR'S SIGNATURE: Arthur B. Krantz
MAR 12 '59

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2.57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3216

CERTIFICATE OF DEATH

03205

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): near - Rock Hall
c. LENGTH OF STAY IN 1b: 3 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Piney Neck Section

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
d. STREET ADDRESS: Piney Neck RFD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edith Middle: Hudson Last: Lemakis

4. DATE OF DEATH: Month: Mar. Day: 10, Year: 1959

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 19, 1902
9. AGE (In years last birthday): 56 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife - & Restaurant
10b. KIND OF BUSINESS OR INDUSTRY: (Self employed)
11. BIRTHPLACE (State or foreign country): Kent Co. Md.
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Charles Henry Hudson
14. MOTHER'S MAIDEN NAME: Emma E. Crouch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
If yes, give war or dates of service:
16. SOCIAL SECURITY NO.: 213-12-5773
17. INFORMANT: Geprge Lemakis Address: 1204 N. 63rd St. Baltimore - 6 Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH
170X
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized Carcinomatosis — Unknown
DUE TO (c): Coronary Thrombosis
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cardiac Cirrhosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 7, 1958 to March 10, 1959, that I last saw the deceased alive on March 10, 1959, and that death occurred at 5:30 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE: Norbert C. Nitsch M.D
ADDRESS (Street, city or town, state): Rock Hall, Md.
DATE SIGNED: Mar. 11, 1959
PHYSICIAN'S NAME (Type): Norbert C. Nitsch

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 13, 1959
22c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel Cem.
22d. LOCATION (City, town, or county) (State): near - Rock Hall, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells
ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: MAR 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur E. Krantz

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [redacted] general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3217 — Reg. Dist. No. — 03206

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): near - Rock Hall
c. LENGTH OF STAY IN 1b: adult life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: At Home

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Near Rock Hall
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Blanche — Middle — Last Page
4. DATE OF DEATH: Month Mar. Day 1, Year 1959

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: July 22, 1875
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New York State
12 CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: James Donnelly
14. MOTHER'S MAIDEN NAME: Elizabeth Beamn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO:
17. INFORMANT: Thos N. Page — Address: Rock Hall, Md. — Husband

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarct
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19 WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 17, 1959, to March 1, 1959, that I last saw the deceased alive on Feb 27, 1959, and that death occurred at 1:20 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: Wm. M. Gatewood, M.D. — ADDRESS (Street, city or town, state): Chestertown, Md. — DATE SIGNED: 3/2/59
PHYSICIAN'S NAME (Type): Wm. M. Gatewood

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 3/4/59
22c NAME OF CEMETERY OR CREMATORY: St. Paul Cem.
22d LOCATION (City, town, or county) (State): near - Chestertown, Md.

23 FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells — ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: MAR 4 '59
24b REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3218 — Reg. Dist. No. 03207

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First MARY Middle EMMA Last PENN
4. DATE OF DEATH: Month March Day 22 Year 19 59
5. SEX: FEM.
6. COLOR OR RACE: WH.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: APR. 15-1879
9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12 CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: SAMUEL COLEMAN
14. MOTHER'S MAIDEN NAME: EMMA NICHOLS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17 INFORMANT: Mrs. Ethel Peterman — Address: R.D. [illegible] Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Senility — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): age
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m.
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 5/19 19[illegible], to 3/22 19[illegible], that I last saw the deceased alive on 3/22 19[illegible], and that death occurred at 4 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E Kester M.D. ADDRESS (Street, city or town, state): Rock Hall DATE SIGNED: 3/24/59

PHYSICIAN'S NAME (Type): E. KESTER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: MAR. 25
22c. NAME OF CEMETERY OR CREMATORY: Emory Chapel
22d LOCATION (City, town, or county) (State): Rock Hall Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar T. Jones — ADDRESS: Church Hill Md.
24a. REC'D BY REGISTRAR DATE: MAR 30 '59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

VS A1S (4)
15M 9/55

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3219 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03208

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Betterton(rural)
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

7 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Betterton(rural)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Michael — Middle: Lee — Last: Plugge
4. DATE OF DEATH: Month: March — Day: 13 — Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct 5 1958
9. AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months: 5 — Days: 8 — IF UNDER 24 HRS.: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Paul Franklin Plugge
14. MOTHER'S MAIDEN NAME: Betty Olive Sparks
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Address: Mrs Betty Plugge(mother) Betterton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ~~Unknown but probably of natural causes~~
DUE TO (b) Tracheobronchitis & Bronchopneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Baby was put in its crib apparently well about 9 PM 3/12/59. Was found dead in its crib at 5:00 AM today.
INTERVAL BETWEEN ONSET AND DEATH: ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ~~Autopsy results not available at time of filling out this~~ certificate.
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour, a. m. / p. m., Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: Robert W. Farr, M.D.
EXAMINER'S NAME (Type): ROBERT W. FARR
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: March 13, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 15, 1959
22c. NAME OF CEMETERY OR CREMATORY: Chester Cem.
22d. LOCATION (City, town, or county) (State): Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells
ADDRESS: Chestertown, Md.
24a. RECD BY REGISTRAR DATE: MAR 16 59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3220

CERTIFICATE OF DEATH

Reg. Dist. No. 03209

1 PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Millington
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH Middle EARL Last PRICE

4. DATE OF DEATH: Month March Day 12, Year 1959

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 2, 1885

9. AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Life Insurance Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Insurance

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Price

14. MOTHER'S MAIDEN NAME: Rachel UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-10-6203

17. INFORMANT: Mrs. Edith Price, Address: Millington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO (b): Meningitis — 2 weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Influenza — 3 weeks

I.C.D. 10.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 27, 19 59, to March 12, 19 59, that I last saw the deceased alive on March 12, 19 59, and that death occurred at 10 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Geza Koralewski M.D. ADDRESS (Street, city or town, state): MILLINGTON MD DATE SIGNED: 3.15 59

PHYSICIAN'S NAME (Type): GEZA KORALEWSKI

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March, 15, 1959

22c. NAME OF CEMETERY OR CREMATORY: Millington Col. Cemetery

22d. LOCATION (City, town, or county): Millington, Kent Co. (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward H. Woods ADDRESS: Millington, Md.

24a. REC'D BY REGISTRAR DATE: MAR 18 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3209

CERTIFICATE OF DEATH

Reg. Dist. No. 03210

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN
c. LENGTH OF STAY IN 1b: 2 MOS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: KENT & QUEEN ANNE'S HOSP.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN
d STREET ADDRESS: 210 WASHINGTON AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARIAN Middle C. Last PRICE
4. DATE OF DEATH: Month MAR Day 17 Year 19 57

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: AUG 2, 1902
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BANK TELLER
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: S. G. CALDWELL
14 MOTHER'S MAIDEN NAME: EMMA STRADLEY

15. WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 214-18-4013
17 INFORMANT — Address: HOSPITAL CHART

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): METASTATIC CARCINOMA OF LIVER — INTERVAL BETWEEN ONSET AND DEATH: 1 year
153.8
DUE TO
(b): PRIMARY CARCINOMA OF COLON
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o m. p m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from APR ____, 19 56, to MAR 17, 19 57, that I last saw the deceased alive on MAR 17, 19 57, and that death occurred at 6 30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. T. Keefe Jr. M.D. — ADDRESS (Street, city or town, state): CHESTERTOWN, Md. — DATE SIGNED: 3.19.59

PHYSICIAN'S NAME (Type): A. T. KEEFE, JR. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 22/59
22c. NAME OF CEMETERY OR CREMATORY: Christ Church Cemetery
22d LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Marvin V. Williams — ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR — DATE: MAR 24 '59
24b REGISTRAR'S SIGNATURE: Clifton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3210 **CERTIFICATE OF DEATH** 03211

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent-Queen Anne's Hosp
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: Queen Annes
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Centerville

3. NAME OF DECEASED (Type or print): First: BABY — Middle: GIRL — Last: RASH

4. DATE OF DEATH: Month: MARCH — Day: 27 — Year: 1959

5. SEX: F

6. COLOR OR RACE: Wh.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/27/59

9. AGE (In years last birthday): yrs — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: 3 — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Farming~~

10b. KIND OF BUSINESS OR INDUSTRY: ~~Farming~~

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: LEWIS WILLIAM RASH

14. MOTHER'S MAIDEN NAME: ELEANOR ELIZABETH CECIL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO — (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: —

17. INFORMANT: Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fetal Atalectasis — INTERVAL BETWEEN ONSET AND DEATH: 2½ hours

DUE TO (b): Prematurity (estimated duration of pregnancy 28 weeks)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: — a. m. p. m. — Month: — Day: — Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State):

21. I certify that I attended the deceased from 3/27, 1959 to 3/27, 1959, that I last saw the deceased alive on 3/27, 1959, and that death occurred at 9:15A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W. Farr M.D. — ADDRESS (Street, city or town, state): — DATE SIGNED: 3/27/59

PHYSICIAN'S NAME (Type): Robert W. Farr, M. D., 305 Washington Ave., Chestertown, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: March 28 1959 — 22c. NAME OF CEMETERY OR CREMATORY: Millington Cemetery — 22d. LOCATION (City, town, or county) (State): Millington Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Pellar — ADDRESS: Millington Md.

24a. REC'D BY REGISTRAR DATE: MAR 31 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, removal, or cremation, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3221

CERTIFICATE OF DEATH

03212

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millington

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Millington

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

/ d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First LEONARD Middle W. Last ROBINSON

4. DATE OF DEATH: Month March Day 19, Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May, 31, 1897

9 AGE (In years last birthday): 61 yrs

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mail Driver

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Mail

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Robinson

14. MOTHER'S MAIDEN NAME: Laura Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-32-0614

17 INFORMANT Address: Marvin Robinson, Millington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chr. Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 10 years

4 1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Portein Myocardial Infarct — 10 years

DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chr. Indigestion

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year: None 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): None

20f. (City or town) (County) (State): the injury

21. I certify that I attended the deceased from Feb, 19 49, to Mar 19, 1959, that I last saw the deceased alive on Mar 19, 1959, and that death occurred at 5:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H.H. Hamilton M.D. ADDRESS (Street, city or town, state): Millington Md DATE SIGNED: 3/2/59

PHYSICIAN'S NAME (Type): H. H. HAMILTON

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March, 22, 1959

22c. NAME OF CEMETERY OR CREMATORY: Millington Cemetery

22d LOCATION (City, town, or county) (State): Millington, Kent Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Edward Fellows Millington Md.

24a. REC'D BY REGISTRAR DATE: MAR 24 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT. M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03213

Reg. Dist. No. 3222

1 PLACE OF DEATH a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): near Chestertown
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): At home RFD # 2

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): near Chestertown (Georgetown Sec.)
d. STREET ADDRESS: RFD # 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Fred — Middle — Last Skipper
4. DATE OF DEATH: Month Mar. Day 30, Year 1959
5. SEX: male
6. COLOR OR RACE: colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Mar. 8, 1881
9. AGE (In years last birthday): 77 yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Junk dealer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Dont know
14. MOTHER'S MAIDEN NAME: Dont know
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: yes
17. INFORMANT: Martha Skipper Address: Chestertown, Md. RFD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: none
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Wheel of car falling or running onto throat and neck
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Was under a car which jacked up, trying to start the car. Car fell or ran off jack and onto deceased's throat & neck.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, item 18): When found, the motor of the car was running & and the car was in reverse gear.
20c. TIME OF INJURY Hour 2:30 p.m. Month, Day 3/30 Year 59 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): own home
20f. (City or town) Chestertown (rural) (County) Kent (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Robert W. Farr MD
EXAMINER'S NAME (Type): Robert W. Farr
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Apr. 1, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Apr. 2, 1959
22c. NAME OF CEMETERY OR CREMATORY: Georgetown Cem.
22d. LOCATION (City, town, or county) (State): near Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Bonne Walley ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: APR 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO IDENTIFY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, omitting the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be recorded to the Chief Medical Examiner's Office along with Form PM3. Page 4 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

VS A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03214

CERTIFICATE OF DEATH

321 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 409 High St.

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 27 Chestertown
d. STREET ADDRESS: 409 High St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Sue — Middle — Last Thompson

4. DATE OF DEATH: Month Mar. — Day 10 — Year 1959

5. SEX: female — 6. COLOR OR RACE: white — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: Apr. 9, 1875 — 9. AGE (In years last birthday): 83 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: George Christhilf
14. MOTHER'S MAIDEN NAME: Laura unk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: unk
17. INFORMANT: Raphael Copper — Address: Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: short time
DUE TO (b): Coronary atherosclerosis — many years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4 a.o.i.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour, o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-1, 1959 to Mar. 10, 1959, that I last saw the deceased alive on Mar. 9, 1959, and that death occurred at 1 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. W. Farr M.D. — ADDRESS (Street, city or town, state): Chestertown, Md. — DATE SIGNED: 3/11/59

PHYSICIAN'S NAME (Type): Robert W. Farr — Chestertown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 12, 1959
22c. NAME OF CEMETERY OR CREMATORY: Chester Cem.
22d. LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells — ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR — DATE: MAR 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kirwan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3212

CERTIFICATE OF DEATH

Reg. Dist. No. 03215

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

c. LENGTH OF STAY IN 1b: 1 da.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [illegible] Chestertown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne Hosp.

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Jerry Middle: [illegible] Last: Townsend

4. DATE OF DEATH: Month: March Day: 10 Year: 19 59

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 9, 1959

9. AGE (In years last birthday): 0 yrs — IF UNDER 1 YEAR: Months: — Days: 1 — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: [illegible]

14. MOTHER'S MAIDEN NAME: [illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): [illegible] (If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO: ----

17. INFORMANT: Hospital Records Address: Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fetal Atalectasis — INTERVAL BETWEEN ONSET AND DEATH: 16 hours

DUE TO (b): Prematurity (estimated duration of pregnancy 30 weeks)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar. 9, 59, to Mar. 10, 1959, that I last saw the deceased alive on Mar. 10, 19 59, and that death occurred at 9:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W. Farr M.D. ADDRESS (Street, city or town, state): Chestertown, Md. DATE SIGNED: 3/11/59

PHYSICIAN'S NAME (Type): Robert W. Farr, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar. 11 /59

22c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery

22d. LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Marvin V. Williams ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: MAR 12 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3223

CERTIFICATE OF DEATH

Reg. Dist. No. 03216

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Rural

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Daniel — Middle: Carroll — Last: Willson

4. DATE OF DEATH: Month: Mar. — Day: 3, — Year: 1959

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar. 9, 1904

9. AGE (In years last birthday): 54 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Bus Driver

10b. KIND OF BUSINESS OR INDUSTRY: owner

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: A. Carroll Willson

14. MOTHER'S MAIDEN NAME: Gertrude Hadaway

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) Yes — If yes, give war or dates of service: WW II

16. SOCIAL SECURITY NO.: 215-20-1539

17. INFORMANT — Address: J. Ernest Willson - Rock Hall, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 10 min.
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on March 3, 1959, and that death occurred at 9:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm. M. Gatewood, M.D. — ADDRESS (Street, city or town, state): Rock Hall, Md. — DATE SIGNED: Mar. 3, 1959

PHYSICIAN'S NAME (Type): Wm. M. Gatewood

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/5/59
22c. NAME OF CEMETERY OR CREMATORY: St. Paul Cemetery
22d. LOCATION (City, town, or county) (State): near - Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells — ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: MAR 6 '59

24b. REGISTRAR'S SIGNATURE: Christine L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3224 — Reg. Dist. No. — 03217

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kennedyville
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Home of Son

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: 411 High St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hester — Middle: Ann — Last: Wiltbank
4. DATE OF DEATH: Month: Mar. — Day: 17, — Year: 1959

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 26, 1871
9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cecil Co. Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joshua Register
14. MOTHER'S MAIDEN NAME: unk Hessey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mrs. Hilda Bennett — Address: 411 High St. Chestertown, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Insufficiency with — INTERVAL BETWEEN ONSET AND DEATH: one hour
420.1
DUE TO (b): Pulmonary edema — 10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Arterial Hypertension

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/17, 1959, to 3/17, 1959, that I last saw the deceased alive on 3/17, 1959, and that death occurred at 12:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W. Farr, M.D. — ADDRESS (Street, city or town, state): Chestertown, Md. — DATE SIGNED: 3/18/59

PHYSICIAN'S NAME (Type): Robert W. Farr

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/19/59
22c. NAME OF CEMETERY OR CREMATORY: Galena Cem.
22d. LOCATION (City, town, or county) (State): Galena Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells — ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR — DATE: MAR 19 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57